

Return Application With
Check Payable To:
NH Board of Pharmacy
Renewal Fee: \$150

State of New Hampshire
Board of Pharmacy
57 Regional Drive
Concord, NH 03301-8518
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

Board Use Only (Do Not Write In This Box)

Check #: _____

LIMITED RETAIL DRUG DISTRIBUTOR OF MEDICAL GASES AND/OR MEDICAL DEVICES

FOR SALE DIRECT TO PATIENT / CONSUMER PURSUANT TO A PRESCRIPTION

APPLICATION FOR PERMIT TO CONDUCT BUSINESS IN THE STATE OF NEW HAMPSHIRE

July 1, 2008 – June 30, 2009 Licensing Period

Location Of Facility From Which Distribution Takes Place:	
_____ <i>Company Name</i>	
_____ <i>Street Address</i>	
_____ <i>City</i>	_____ <i>State</i>
_____ <i>Zip Code</i>	
Parent Company (If Applicable):	
State Of Incorporation (If Corp.):	
Nature Of Retail Business (Check ALL That Apply): <input type="checkbox"/> Medical Gas Distributor <input type="checkbox"/> Medical Device Distributor <input type="checkbox"/> Other _____	Doing Business As: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> LLC
Telephone:	E-Mail Address:

Name Of Owner(s): Indicate Individual, Partners, Etc. (If Corporation, Show Title Of Officers). Attach Additional Sheet If Necessary.		
Name	Address	Title
_____ Name	_____ Address	_____ Title
_____ Name	_____ Address	_____ Title

Is the above referenced company (physical location) licensed by the board of pharmacy in the state of location? <input type="checkbox"/> Yes * <input type="checkbox"/> No *(If "yes", attach a copy of the state license/permit & the most recent inspection).

Has registration or licensure granted to the above referenced company by any state or federal agency ever been suspended, revoked, or otherwise disciplined? <input type="checkbox"/> Yes * <input type="checkbox"/> No *(If "Yes", attach a detailed explanation)
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Provide the name, address, & title of the person to whom the permit and/or renewal application should be directed:		
Name:	Title:	Tel. #:
Business Mailing Address:		

APPLICATION CONTINUED ON OTHER SIDE ⇌- ⇌- ⇌- ⇌- ⇌- ⇌

Declaration And Signature Of Company Representative:

I have attached the following required documents:

- ☐ A **copy of the state license** from the state licensing agency where the facility is located, if located outside New Hampshire.
- ☐ A **copy of the facility's most recent inspection report** completed by the state licensing board/agency where the facility is domiciled, if located outside New Hampshire.

I affirm that I am the person authorized to sign this application for licensure and declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the registration herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State.

Signature: _____ Title: _____ Date: _____

INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT REQUIRED ATTACHMENTS WILL NOT BE ACCEPTED.

**ANY SUBSEQUENT CHANGES TO THE INFORMATION ON THIS FORM
MUST BE REPORTED TO THE BOARD IN WRITING WITHIN 15 DAYS.**